wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Opticians
Optometrists
Physician Clinics
Physicians
HMOs and Other Managed Care Programs

Changes to local codes, paper claims, and prior authorization for vision services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes, paper claims, and prior authorization (PA) for vision services, effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising Medicaid PA request forms and instructions.

A separate *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing and prior authorization (PA) changes for vision services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A separate *Update* will notify providers of the specific effective dates for the various changes. These changes include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.
- Revising PA request forms and instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes, revised paper claim instructions, or revised PA forms and instructions prior to implementation dates may result in claim denials and returned PA requests. Specific implementation dates will be published in a separate *Update*.

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for vision services.

Allowable procedure codes

Wisconsin Medicaid will adopt *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes to replace currently used Wisconsin Medicaid local procedure codes (W0220-W8525) for vision services. Refer to Attachment 1 of this *Update* for a procedure code conversion chart. Providers will be

required to use the appropriate procedure code that describes the service performed. Refer to Attachment 2 for a list of allowable procedure codes for submitting claims for permanent (silicone) punctal plug devices and the surgical procedure for implanting them. Punctal plug insertion and materials are now covered by Wisconsin Medicaid for both ophthalmologists and optometists.

Providers should continue to refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers.

Discontinued local codes

The following procedure codes are being discontinued and will not be replaced by national procedure codes:

- W8000 — Ptosis crutch (fitting and supply).
- W8193 — Dispensing fee.
- W8197 — Vision training and therapy.
- W8198 — Contact lens and therapy.

Providers should use the CPT or HCPCS code that best describes the item or procedure.

Type of service codes

Type of service codes will no longer be required on Medicaid claims and PA requests.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 3 for a list of allowable POS codes for vision services.

Modifiers

Wisconsin Medicaid will adopt nationally recognized modifiers to replace the local modifiers used currently by Wisconsin Medicaid. Some of these modifiers are locally defined by Wisconsin Medicaid for vision providers. Refer to Attachment 1 for allowable modifiers for vision services providers.

Coverage for vision services

Medicaid coverage and documentation requirements for ophthalmologists, optometrists, and opticians will remain unchanged. Refer to the Vision Care Services Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified ophthalmologists, optometrists, and opticians will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 4 for the revised instructions. Attachment 5 is a sample of a claim for vision services that reflects the changes to the billing instructions.

With the implementation of HIPAA, Medicaid-certified ophthalmologists, optometrists, and opticians will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update*, even though the actual CMS 1500 claim form is not being revised at this time.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

Revisions made to the CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Claim sort indicator "P" is used for all services (Element 1).
- Other insurance indicators were revised (Element 9).
- Medicare disclaimer codes were revised (Element 11).
- Outside lab indicator is no longer required (Element 20).
- Place of service codes were revised (Element 24B).

- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).
- Spenddown amount should no longer be entered (Element 24K). Wisconsin Medicaid will automatically reduce the provider's reimbursement by the recipient's spenddown amount.

Revision of prior authorization request forms and instructions

With the implementation of HIPAA, vision providers will be required to use the revised Prior Authorization Request Form (PA/RF), HCF 11018, dated 06/03. Instructions for completion of this revised form are located in Attachment 6. A sample PA/RF is in Attachment 7.

The PA/VA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site.

Revisions made to the Prior Authorization Request Form

The following revisions were made to the PA/RF:

- Space for performing provider number added for each service/procedure (Element 15).
- Space added for additional modifiers (Element 17).
- Place of service codes were revised (Element 18).
- Type of service codes are no longer required.

Prior authorization attachments

The Prior Authorization / Vision Attachment (PA/VA), HCF 11051, dated 06/03, has also been revised. The basic information requested on the form has not changed; only the format of the form has changed. Refer to Attachment 8 for a copy of the completion instructions for the PA/VA. Attachment 9 is a copy of the PA/VA for providers to photocopy.

Obtaining prior authorization request forms

The PA/VA is available in a fillable Portable Document Format (PDF) from the forms page of the Wisconsin Medicaid Web site. (Providers cannot obtain copies of the PA/RF from the Medicaid Web site since each form has a unique, preprinted PA number on it.) To access the PA/VA and other Medicaid forms, follow these instructions:

1. Go to *www.dhfs.state.wi.us/medicaid/*.
2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

The fillable PDF may be accessed using Adobe Acrobat Reader®* and may be completed electronically. Providers may then include the printed version of the attachment with the PA/RF. To use the fillable PDF, click on the dash-outlined boxes to enter information. Press the "Tab" key to move from one box to the next.

To request paper copies of the PA/VA or PA/RF, call Provider Services at (800) 947-9627 or (608) 221-9883. Questions about the forms may also be directed to Provider Services at the telephone numbers previously mentioned.

In addition, all PA forms and attachments are available by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the HCF number of the form (if applicable), and the number of copies requested, and send the request to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.
- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

* The Medicaid Web site provides instructions on how to obtain Adobe Acrobat Reader® at no charge from the Adobe® Web site at *www.adobe.com/*. Adobe Acrobat Reader® does not allow users to save completed fillable PDFs to their computer. Refer to the Adobe® Web site for more information on fillable PDFs.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Procedure code conversion chart for vision services

The following table lists the nationally recognized procedure codes that providers will be required to use when submitting claims for vision services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation	**After HIPAA implementation**	
Local procedure code and description	**National procedure code and description**	**Modifier**
W8001 Therapeutic "bandage" lens. Fitting and supply	**92070** Fitting of contact lens for treatment of disease, including supply of lens	
W8004 New patient, low vision diagnosis, evaluation	**92002** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	
	92004 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits	
	99201 Office or other outpatient visit for the evaluation and management of a new patient: problem focused history/exam and straight forward medical decision making	
	99202 Office or other outpatient visit for the evaluation and management of a new patient: expanded problem-focused history/exam and straight forward medical decision making	
	99203 Office or other outpatient visit for the evaluation and management of a new patient: detailed history/exam and medical decision making of low complexity	
	99204 Office or other outpatient visit for the evaluation and management of a new patient: comprehensive history/exam, medical decision making of moderate complexity	
	99205 Office or other outpatient visit for the evaluation and management of a new patient: comprehensive history/exam, medical decision making of high complexity	

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	**National procedure code and description**	**Modifier**
W8009 Established patient, low vision diagnosis, evaluation	**92012** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	
	92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits	
	99211 Office or other outpatient visit for the evaluation and management of an established patient: minimal presenting problem	
	99212 Office or other outpatient visit for the evaluation and management of an established patient: problem focused history/exam, straight forward medical decision making	
	99213 Office or other outpatient visit for the evaluation and management of an established patient: expanded problem focused history/exam, medical decision making of low complexity	
	99214 Office or other outpatient visit for the evaluation and management of an established patient: detailed history/exam, medical decision making of moderate complexity	
	99215 Office or other outpatient visit for the evaluation and management of an established patient: comprehensive history/exam, medical decision making of high complexity	
W8110 Lens formula	**V2100-V2199*** Single vision, glass or plastic	**U3** High index
		SC Medically necessary service or supply
	V2200-V2299* Bifocal, glass or plastic	**U4** High index
		SC Medically necessary service or supply
	V2300-V2399* Trifocal, glass or plastic	**U4** High index
		SC Medically necessary service or supply
	V2740 Tint, plastic, rose 1 or 2, per lens	**SC** Medically necessary service or supply
	V2742 Tint, glass, rose 1 or 2, per lens	**SC** Medically necessary service or supply
	V2744 Tint, photochromatic, per lens	**SC** Medically necessary service or supply
	V2755 U-V lens, per lens	**SC** Medically necessary service or supply

* Refer to the Healthcare Common Procedure Coding System (HCPCS) Level II code book for complete definitions.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	**National procedure code and description**	**Modifier**
W8110 Lens formula	**V2780** Oversize lens, per lens	**SC** Medically necessary service or supply
	V2781 Progressive lens, per lens	**SC** Medically necessary service or supply
	S0580 Polycarbonate lens	**SC*** Medically necessary service or supply
	S0504-S0510** Safety lenses	**SC** Medically necessary service or supply
W8112 Fitting of spectacles, changed prescription, complete appliance, single vision	**92340** Fitting of spectacles, except for aphakia; monofocal	**U5** Changed prescription, single
	92352 Fitting of spectacle prosthesis for aphakia; monofocal	**U5** Changed prescription, single
W8113 Fitting of spectacles, changed prescription, complete appliance, bifocal or multifocal	**92341** Fitting of spectacles, except for aphakia; bifocal	**U6** Changed prescription, bifocal or multifocal
	92342 Fitting of spectacles, except for aphakia; multifocal, other than bifocal	**U6** Changed prescription, bifocal or multifocal
	92353 Fitting of spectacle prosthesis for aphakia; multifocal	**U6** Changed prescription, bifocal or multifocal
W8130 Frames name and manufacturing	**V2020** Frames, purchases	**SC** Medically necessary service or supply
	S0516 Safety eyeglass frames	**SC** Medically necessary service or supply
W8132 Temple name and manufacturing	**V2020** Frames, purchases	**SC** Medically necessary service or supply
W8190 Dispensing of non-contracted materials and other miscellaneous services	**V2799** Vision service, miscellaneous	**SC** Medically necessary service or supply
W8191 Minor repair	**92370** Repair and refitting spectacles; except for aphakia	
	92371 Repair and refitting spectacles; spectacle prosthesis for aphakia	
W8520 Frame replacement, dispensing fee	**V2020** Frames, purchases	**U7** Frame replacement, dispensing fee
W8522 Temple replacement, dispensing fee	**V2020** Frames, purchases	**U8** Temple replacement, dispensing fee

* The modifier "SC" is only required for procedure code S0580 when the recipient is 21 years old or over.

** Refer to the HCPCS Level II code book for complete definitions.

Before HIPAA implementation	After HIPAA implementation	
Local procedure code and description	**National procedure code and description**	**Modifier**
W8523 Lens replacement, changed prescription, single vision, dispensing fee	**92340** Fitting of spectacles, except for aphakia; monofocal	**U9** Lens replacement, changed prescription
	92352 Fitting of spectacle prosthesis for aphakia; monofocal	**U9** Lens replacement, changed prescription
W8524 Lens replacement, changed prescription, bifocal or multifocal, dispensing fee	**92341** Fitting of spectacles, except for aphakia; bifocal	**U9** Lens replacement, changed prescription
	92342 Fitting of spectacles, except for aphakia; multifocal, other than bifocal	**U9** Lens replacement, changed prescription
	92353 Fitting of spectacle prosthesis for aphakia; multifocal	**U9** Lens replacement, changed prescription
W8525 Lens replacement, unifocal dispensing fee	**92341** Fitting of spectacles, except for aphakia; bifocal	**RP** Replacement and repair
	92342 Fitting of spectacles, except for aphakia; multifocal, other than bifocal	**RP** Replacement and repair
	92353 Fitting of spectacle prosthesis for aphakia; multifocal	**RP** Replacement and repair

ATTACHMENT 2
Punctal plug procedure codes for vision services

The following table lists the allowable procedure codes that providers should use when submitting claims for punctal plugs.

Procedure code	Description	Modifier
A4263	Permanent, long-term, nondissolvable lacrimal duct implant, each	
68761	Closure of the lacrimal punctum; by plug, each	**E1** Upper left, eyelid
		E2 Lower left, eyelid
		E3 Upper right, eyelid
		E4 Lower right, eyelid
		50 Bilateral procedure (both lower eyelids)

ATTACHMENT 3
Place of service codes for vision services

The following table lists the allowable place of service (POS) codes that providers should use when submitting claims after Health Insurance Portability and Accountability Act of 1996 (HIPAA) implementation.

POS code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

ATTACHMENT 4
CMS 1500 claim form instructions for vision services

(For claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

Ophthalmologists: Enter claim sort indicator "P" for the service billed in the Medicaid check box.

Opticians and optometrists: Enter claim sort indicator "V" for the service billed in the Medicaid check box.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only, or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, **and** the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes **must** be indicated in the **first** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the **first** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Home health agency, medical equipment vendor, pharmacy, and physician providers must be Medicare enrolled to provide Medicare-covered services for dual entitlees. Dual entitlees are those recipients covered under both Medicare and Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost ("MCC") or Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis, and manifestation ("M") codes are not acceptable. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing multiple DOS for the same calendar month and on the same detail line, enter the month's first DOS in MM/DD/YY format in the "From" field. Enter the month's last DOS in the "To" field in MM/DD/YY format.

Element 24B — Place of Service

Enter the appropriate two-digit place of service (POS) code for each service. Refer to Attachment 2 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D. Please note that Wisconsin Medicaid has not adopted all national modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG

Enter an "E" for **each** procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure if that number is different than the billing provider number in Element 33. Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered

If services were provided to a recipient in a nursing home (POS code "31" or "32"), indicate the nursing home's eight-digit Wisconsin Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and Zip code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 5
Sample CMS 1500 claim form for vision services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
(Medicare #) (Medicaid #) P (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY — STATE

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX)XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 365.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 16 03		11		92014		1	XX XX	1				87654321
2 12 16 03		11		92083		1	XX XX	2				87654321
3 12 16 03		11		92100		1	XX XX	2				87654321
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# — GRP# 65432109

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 6
Prior Authorization Request Form (PA/RF) Completion Instructions for vision services

(For prior authorization requests following HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Vision Services Attachment (PA/VA), by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit the PA request with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. No other information should be entered in this element, since it also serves as a return mailing label.

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type

Enter processing type "122"; this code is for vision services. The processing type is a three-digit code used to identify the category of service requested.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis of V53.1 cannot be used as the primary or sole diagnosis.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date (not required)

Element 15 — Performing Provider Number
Enter the eight-digit Medicaid provider number of the provider who will be providing the service, *only* if this number is different from the billing provider number listed in Element 4.

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 17 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 19 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 20 — QR
Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

Element 21 — Charge
Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges
Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 7
Sample Prior Authorization Request Form (PA/RF) for vision services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider, O.D. **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**122**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial)	9. Sex — Recipient	
Recipient, Im A.	❑M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
366.9 Unspecified Cataract		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
368.13 Photophobia		

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
	V2744	**SC**				**11**	**Tint, photochromatic, per lens**	**2**	**XX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges**	**XX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized: Quantity Authorized:

❑ Approved

Grant Date _____ Expiration Date _____

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ _____
SIGNATURE — Consultant / Analyst Date Signed

ATTACHMENT 8
Prior Authorization / Vision Services Attachment (PA/VA) Completion Instructions

(A copy of the "Prior Authorization/Vision Services Attachment [PA/VA] Completion Instructions" are located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11051A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / VISION ATTACHMENT (PA/VA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining the eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Vision Services Attachment (PA/VA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Use the recipient's Medicaid identification card or the EVS to obtain the correct identification number.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Referring / Prescribing Provider
Enter the name of the referring/prescribing provider, if available.

Element 5 — Referring / Prescribing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the referring/prescribing provider, if available.

Element 6 — Telephone Number — Referring / Prescribing Provider
Enter the referring/prescribing provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Element 7 — Lenses and Frames
List information regarding lenses and frames. Lens formula information is required for all requests for frames and lenses.

Element 8 — Special Lens / Frame Request
List information regarding special lens/frame request. Lens formula information is required for all requests for frames and lenses.

Element 9 — Tints
List information regarding lens tint. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

Element 10 — Other Vision Services Requested
Indicate any other vision services requested, including a description of the services requested, pertinent history/findings, and justification.

Element 11 — Signature — Requesting / Performing Provider
Enter the signature of the requesting/performing provider.

Element 12 — Date Signed
Enter the month, day, and year the PA/VA was signed (in MM/DD/YYYY format).

ATTACHMENT 9
Prior Authorization / Vision Services Attachment (PA/VA) (for photocopying)

(The "Prior Authorization/Vision Services Attachment [PA/VA]" [for photocopying] is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11051 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / VISION SERVICES ATTACHMENT (PA/VA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Vision Services Attachment (PA/VA) Completion Instructions (HCF 11051A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Referring / Prescribing Provider

5. Referring / Prescribing Provider's Medicaid Provider Number

6. Telephone Number — Referring / Prescribing Provider

SECTION III — DOCUMENTATION

7. Lenses and Frames (Lens formula information is required for all requests for frames and lenses.)

Lens formula: (L) _____ Add _____

(R) _____

❑ Replacement only

Frame name: _____

Frame manufacturer: _____

❑ Replacement only
❑ Complete appliance (lenses and frames)

8. Special Lens / Frame Request

❑ Oversize ❑ Patient supplied frame ❑ Noncontract frame (not supplied by recipient)
❑ Add over +4.00 ❑ Contract lab supplied frame

Justification for noncontract frame (principal justification may not be cosmetic; principal justification must be medically / visually necessary): _____

❑ Other (provide pertinent history / findings and justification along with specifics of request): _____

If request is for a noncontract item, estimate wholesale cost: _____

Continued

SECTION III — DOCUMENTATION (Continued)

9. Tints (All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation, is insufficient justification.)

❑ Rose 1 ❑ Rose 2 ❑ Photochromic

❑ Other tint (explain): _____

_____

_____

Justification for tint (see above): _____

_____

_____

_____

10. Other Vision Services Requested (Include a description of services requested, pertinent history / findings, and justification.)

11. **SIGNATURE** — Requesting / Performing Provider	12. Date Signed